FIX. 14 1 E.D. 05/02/2018 05/02/2018 WED 16:08 FAX 6157417051 TOOR HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE OMB NO. 0938-039 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEPICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING_ 04/18/2018 445170 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 500 HICKORY HOLLOW TERRACE GOOD SAMARITAN HEALTH AND REHAB CENTER ANTIOCH, TN 37013 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 F 000 INITIAL COMMENTS A recertification survey and complaint Investigation #43690 were completed on 4/16/18 - 4/18/18 at Good Samaritan Health & Rehab Center. Deficiencies were cited during the recertification survey at a HARM (a situation in which the provider's noncompliance resulted in a negative outcome that had compromised the resident's ability to maintain and/or reach his/her hightest practical physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services) for failure to appropriately update and complete a comprehensive care plan, notify the Medical Director timely a fall occurred, and failure to provide pain management for Resident #239 which resulted in a fracture. What corrective action(s) F 578 F 578 : Request/Refuse/Dscntnue Trmnt; Formite Adv Dir will be accomplished for SS=D CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) those residents found to §483.10(c)(6) The right to request, refuse, and/or have been affected by the discontinue treatment, to participate in or refuse deficient practice. to participate in experimental research, and to formulate an advance directive. The resident/responsible §483.10(c)(8) Nothing in this paragraph should be i party for resident #86 was construed as the right of the resident to receive notified for validity of the the provision of medical treatment or medical correct code status 4/18/18. services deemed medically unnecessary or inappropriate. The Advance Directive for §483,10(g)(12) The facility must comply with the Resident #86 was reviewed requirements specified in 42 CFR part 489, for accuracy and completeness. subpart I (Advance Directives). The incorrect copy was (i) These regulrements include provisions to Inform and provide written information to all adult removed from the residents concerning the right to accept or refuse chart. (XII) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excluded from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloseble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discloseble 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

Leciend 5-8-18

If continuation sheet Page 1 of 2

05/02/2018 WED 16:08 FAX 6157417051 TDOH HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVE OMB NO. 0938-039

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(×3) DA	ATE SURVEY OMPLETED
		445170	B. WING	,	04	4/18/2018
	PROVIDER OR SUPPLIER AMARITAN HEALTH	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013	100 to 10	
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F 000	INITIAL COMMEN	rş	F 00	00		
F 578 SS∞D	- 4/18/18 at Good S Center. Deficiencie recertification surve which the provider's negative outcome to resident's ability to a hightest practical pit psychosocial well-b accurate and compi- assessment, plan of services) for fallure complete a compret Medical Director time to provide pain man which resulted in a st Request/Refuse/Os CFR(s): 483.10(c)(6) §483.10(c)(6) The ri- discontinue treatme to participate in experimental an advance §483.10(c)(8) Nothin construed as the rig the provision of medical services deemed me inappropriate. §483.10(g)(12) The requirements specific subpart I (Advance II (I) These requirement inform and provide veresidents concerning	of were completed on 4/16/18 camaritan Health & Rehab is were cited during the sy at a HARM (a situation in a noncompliance resulted in a hat had compromised the maintain and/or reach his/her hysical, mental and eing as defined by an rehensive resident of care and provision of to appropriately update and hensive care plan, notify the hely a fall occurred, and failure agement for Resident #239 fracture. continue Trimit; Formite Adv Dir is (8)(g)(12)(i)-(v) ight to request, refuse, and/or int, to participate in or refuse erimental research, and to be directive. Ing in this paragraph should be hit of the resident to receive lical treatment or medical edically unnecessary or facility must comply with the ed in 42 CFR part 489.	F 57	How will you identify residents having the potential to be affected the same deficient prayand what corrective as will be taken; All residents' charts we audited 4/19/18 to ensure and accurate ins-services were conducted 4/19/18 regarding the importance of the Advance Directive being complete accurate.	ere sure are tucted	(XS) DATE

Any deficiency statement ending with an esteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Provious Versions Obsolete

Event ID: 24XE11 Facility ID: TN1908

If continuation sheet Page 1 of 26

05/02/2018 WED 16:08 FAX 6157417051 TOOH HCP DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/02/201 FORM APPROVE OMB NO. 0938-039

CENTER	RS FOR MEDICARI	E & MEDICAID SERVICES		- 1944 TV - 100 TV - 20		7777 77	
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		445170	B. WING			18/2018	
NAME OF F	PROVIDER OR SUPPLIER		1140 14	STREET ADDRESS, CITY, STATE, 2IP C	CODE		
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GOODS	AMARITAN HEALTH	AND REHAB CENTER		ANTIOCH, TN 37013			
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F 578	Continued From paredical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Stalling (iii) Facilities are presentities to furnish the legally responsible requirements of this (iv) If an adult indivitime of admission and information or articulation and information or articulation and information or articulation and information or articulation information or articulation information or articulation information or articulation information or she is able to refollow-up procedu the information to the i	age 1 I treatment and, at the ormulate an advance directive written description of the implement advance directives to law. The information but are still for ensuring that the section are met. Tidual is incapacitated at the and is unable to receive ulate whether or not he or she dvance directive, the facility directive information to the it representative in accordance of relieved of its obligation to ation to the individual once he ceive such information. The smust be in place to provide the individual directly at the individual directly at the individual directly at the individual once description in the electronic medical ampled residents (Resident #86 was lity on 3/10/18 with diagnoses its Disease, Heart Failure,	F 578		s Staff Advance esident ble party sion. will verify alidate ance Directive. I Care Plan 48 hrs.) IDT the Advance ie family to		
	Dysphagia, Adult Fallure to Thrive and Dementia.			4. Medical Records	will audit		
		ew of the electronic medical #86 on 4/16/18 at 4:10 PM		For compliance.		j	

NAME OF PROVIDER OR SUPPLIER

(X4) (D

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TAG

05/02/2018 WED 16:09 FAX 6157417051 TDOH HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ 445170

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

FRINTED: 05/02/ FORM APPRO OMB NO. 0938-0 (X3) DATE SURVEY

COMPLETED

(X5) COMPLET DATE

04/18/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE

ANTIOCH, TN 37013

B. WING

PREFIX

TAG

F 578

GOOD SAMARITAN HEALTH AND REHAB CENTER

F 578 Continued From page 2 and 4/18/18 at 9:50 AM revealed the resident's advanced directive (codes status) was Cardlopulmonary Resuscitation (CPR) indicating she preferred life saving interventions if she has no pulse and is not breathing.

> Medical record review of Resident #86's hard chart revealed a POST (Physician Order for Scope of Treatment - a document completed by a healthcare professional, signed by a Physician based on patient preferences and medical indications) form dated 3/10/18. Continued review : revealed the resident preferred a code status of Do Not Resuscitate (DNR) indicating to allow natural death if she has no pulse and is not breathing.

Interview with the charge nurse, Licensed Practical Nurse (LPN) #5 on 4/18/18 at 9:50 AM at the nurses station after viewing Resident #86's, ! home page on the electronic medical record and the hard chart copy of the POST form confirmed the electronic medical record and hard copy POST form were not the same. Further interview confirmed the hard copy POST form was the correct document to follow. The LPN (#5)confirmed the facility failed to maintain accurate code status for Resident #86 in the electronic medical record.

F 580 Notify of Changes (Injury/Decline/Room, etc.) SS=G CFR(s): 483.10(g)(14)(i)-(iv)(15)

> §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

GROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

The QAPI Committee will monitor the effectiveness of the Interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director

(SEE ATTACHMENT "C")

FORM CMS-2507(02-99) Previous Versions Obsolete

Event ID: 24XE11

Facility ID: TN1909

F 580

If continuation sheet Page 3 of 26

05/02/2018 WED 16:09 FAX 6157417051 TOOH HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2 FORM APPRO OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULT A BUILDIN		(X3) DATE SURVE COMPLETED		
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	i physician Interventic (B) A significant characterioration in heat status in either life-collinical complication (C) A need to alter to a need to discontinut treatment due to ad commence a new form (D) A decision to train the fact of the section	has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lith, mental, or psychosocial threatening conditions or is); reatment significantly (that is, is an existing form of verse consequences, or to orm of treatment); or insfer or discharge the cility as specified in offication under paragraph (g) in, the facility must ensure that the specified in §463.15(c)(2) yided upon request to the also promptly notify the ident representative, if any, in or roommate assignment 10(e)(6); or lent rights under Federal or ons as specified in paragraph in record and periodically malling and email) and	F 58	What corrective actions will be accomplished for those residents found thave been affected by the deficient practice. The Medical Director was notified of the "Immedia Jeopardy" citation 4/17/@ 8:30pm. The facility assigned a "Stobe in the room with Resident #239 4/17/18 @ The family was informed @ 7:01pm. Resident' call was updated accordingly. The nurse assigned to Reson the day of the incident suspended 4/17/18 @ 10	or to the as ate /18 Sitter" @ 7:01pm. d 4/17/18 are plan y 4/17/18. esident #239 at was		

05/02/2018 WED 16:10 FAX 6157417051 TOOH HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	room changes bet under §483.15(c)(s). This REQUIREME by: Based on facility possible review, facility investigation of the Physician prolonged pain to the structural and psychosan accurate and conassessment, plan of services). Findings include: Review of facility possible promptly notify the Physician of the resulted in a negative and/or reach his/hemental and psychosan accurate and conassessment, plan of services). Findings include: Review of facility possible promptly notify changes in the residentian and/or states admitted to the feadmitted on 4/2/18	ecify the policies that apply to ween its different locations (a). NT is not met as evidenced colicy review, medical record stigation review, Physician es, Radiology Report and by falled to notify the Medical Physician immediately after 1	F 580	How will you identify otheresidents having the potential to be affected by the same deficient practice and what corrective action will be taken; In-service training was give the nursing staff regarding Notification to physician an family beginning 4/17/18 a will be on going to ensure a staff that were not present the first training session recthe training prior to beginn their shift. "In-service Train Sheets Attached). (SEE ATTACH MEM "E	en to all at ceive ling	

05/02/2018 WED 16:10 FAX 6157417051 TOOH HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES

PHINTED: 05/02/ FORM APPRO OMB NO. 0938-0

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l .	SUMMARY S (EACH DEFICIEN	R HAND REHAB CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	6	TREET ADDRESS, CITY, STATE, ZIP COO 00 HICKORY HOLLOW TERRACE INTIOCH, TN 37013 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION HOULD BE	4/18/201		
Frida Rank	Muscle Weakness and Mobility. Hear Diverticulosis of St. Cardiomyopathy, C. Disease, Adult Fai Angle-Closure Gla. Medical record rev. Data Set dated 3/2 had a Brief Interviee 11, indicating mild of required extensive transfers, dressing, and required total of Continued review resteady and only ables assistance for movinosition. Further rev. Was at risk for falls assistance admission (3/2). Review of a facility I revealed Resident # racture at 5:00 AM Director/Attending PM and 8:30AM with Review of a Physicial 449 (2:49PM) reverse the Attending Physicial 4	cons, Other Reduced Mobility, a, Other Abnormalities of Gait of Failure, Altered Mental Status, mall Intestine, Ischemic Chronic Obstructive Pulmonary fure to Thrive and Acute ucoma. iew of a Discharge Minimum 6/18 revealed Resident #239 of for Mental Status score of cognitive impairment and assistance with bed mobility, tolleting and personal hygiene dependence for bathing, avealed the resident was not e to stabilize with staffing from a seated to standing view revealed Resident #239 and had a fall with major injury 23/18). Investigation dated 3/26/18 at a led a phone order received in the Medical chysician was notified at 7:30 on no response documented. In Order dated 3/26/18 at aled a phone order received is a phone order received	F 580	What measure will be put into place or what systems changes you will make to ensure that the deficient practice does not recur; and The facility has implemente written "Protocol for notify! Physician and Family" when change in the resident's condition or status occurs. (See attachment "A"). Medical Records and QAPI staff will conduct daily audits to ensure compilance.	atic d d a lng			

05/02/2018 WED T6:11 FAX 6157417051 TDOM HCF

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING			
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9	PROVIDER OR SUPPLIER AMARITAN HEALTH	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, 2 500 HICKORY HOLLOW TERRA ANTIOCH, TN 37013	ZIP CODE		
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F 600 SS=0	to MD. Order obtain [hospital named] EF AMR ambulance se AMR ambulance se Medical record reviet had a fall on 3/26/18 (HARM). Further review as admitted to the on 3/28/18 to repair Interview with the M Physician on 4/18/18 revealed he expecte all falls. Interview with the DO the conference room reported immediately Director/Attending Prevealed the survey referenced fall and the falled to notify the Michael Physician immediately (Resident #239). Free from Abuse and CFR(s): 483.12(a)(1) (3/483.12 Freedom from Exploitation The resident has the neglect, misappropriation as dencludes but is not limporporal punishment,	"mobile xray resultes called need to send resident to a for Eval. and Tx. as ordered. Invice to transport" Sew revealed Resident #239 3 which resulted in a fracture view revealed the resident hospital and received surgery the fracture. edical Director/Attending at 5:00 PM by telephone at to be called immediately for DN on 4/18/18 at 5:45 PM in a confirmed all falls should be at the medical hysician. Continued interview team reviewed the above the DON confirmed the facility edical Director/Attending by for 1 fall for 12 residents. I Neglect In Abuse, Neglect, and aright to be free from abuse, atlon of resident property, affined in this subpart. This inted to freedom from involuntary seclusion and ical restraint not required to	F 58	the deficient practice recur; i.e., what qua assurance program is put into place. The QAPI Committee monitor the effective of the interventions implemented and the members include Add Assistant Administra DSD, QA Coordinator Coordinator, Activity Dietary Manager, Rel Manager, Social Servi Plant & Maintenance Medical Records Manager and RN/CNT. Monitor be conducted daily, we monthly or as ordered Medial Director	ensure will not will be will be will be ministrator, itor, DON, MOS Manager, hab ices Director, Manager ring will weekly,		

05/02/2018 WED 16:12 FAX 6157417051 TOOH HOF DEPARTMENT OF HEALTH AND HUMAN SERVICES M013/039 PRINTED: 05/02/201 FORM APPROVE OMB NO 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES					MB NO. 0938-03	
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	physical abuse, convoluntary seclus. This REQUIREMED by: Physician's Orders and interview, the and services neces prompt medical at fracture for 1 of 27 #239) resulting in provider's noncomoutcome that had ability to maintain practical physical, well-being as defined and provision of second provision of s	use verbal, mental, sexual, or orporal punishment, or lon; int is not met as evidenced in control in the compromised the resident is and/or reach nis/her hightest mental and psychosocial med by an accurate and sident assessment, plan of care envices). If we revealed Resident #239 is facility on 3/23/18 and in the control in the contr	F 60	What corrective action(s will be accomplished for those residents found to have been affected by the deficient practice. At Sam, 4/27/18, time resident #239 was obsers on the floor; staff assess for ROM, vital signs, leve consciousness and evaluation for possible injury and particular denied pain and did not express any signs symptoms of pain. Staff continued to monite and conduct neuro check When the resident complained of pain later in the morning the Physic was called and order received to send resident for X-ray. X-ray results resident for further evand treatment. Ambulan called and arrived later in afternoon and transporter resident to hospital.	ved ed her l of ated ain. ne cor ss. clan eived eveal lan esident aluation ce n the	

05/02/2018 WED 16:12 FAX 6157417051 TOOH HOF DEPARTMENT OF HEALTH AND HUMAN SERVICES Ø014/039 PKINTED: 05/02/20 FORM APPROVE OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		(XI) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING				
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	and required total of Continued review in Steady and only ab assistance. Further #239 was at risk for injury since admission Medical record reviewelled on 3/26/1 was found in a root on the floor behind revealed at 6:30 Af pain to the right this Medical record reviewelled "(at) application on the floor behind revealed "(at) application of the record reviewelled "(at) application of the therapist. Endorse right leg to Incominate (follow-up) [with] Medical record reviewelled resident fracture at 5:00 AN Director/Altending	tolleting and personal hygiene dependence for bathing. evealed the resident was not let to stabilize with staff review revealed Resident falls and had a fall with major ion. ew of a facility investigation at 5:00 AM Resident #239 across from her room, sitting a couch. Continued review of the resident complained of ght. ew of a statement dated alcensed Practical Nurse #6 proximately 7AM patient was in implained of pain to right leg apist when she tried to stand exported to this writer by the diffusion to form the complaint of pain to grunning supervisor to flu D" ew of a statement dated Physical Therapist #1 revealed to P.T. (physical therapy) gymbars. Patient unable to Patient then told therapist she st took patient back to nurse attent's pain" investigation dated 3/26/18 #239 had a fall resulting in	F 6	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; O4/17/18 staff began reassall residents at risk for pair All those identified as" hig for pair will be further evalualizing the root cause an Physician will be notified analysis results. Plan of a be updated based on the assessment findings. 4/17/18 an audit was conforthe fall incidents utilizing "The Morse Code Fall Asse for the period of February and April 2018. Those identified as higher falls will be further evalual utilizing the" Root Cause to determine the individual intervention appropriate resident and will be docuon the Plan of Care.	y te n sessing n, th-risk" aluated alysis. of pain are will ducted ng essment" r, March lisk for ated analysis" ral for each		

05/02/2018 WED 16:13 FAX 6157417051 TOOH HCF

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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(X4) ID PREFIX TAG	VENCH PREICIENT	TATEMENT OF DEFICIENCIES TO MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(XS) COMPLETION DATE
F 600	1449 (2:49PM) reply the Attending Figure 1449 (2:49PM) repelvis, pelvis [sic], Review of a Radio 8:02 PM revealed right subcapital high fracture with sligh. Review of a Nurse (9:00 PM) revealed to MD. Order obtation from 1440 (1:40 pm) revealed to MD. Order obtation Reported at the first period of 3/26/18. Continued of 3/26/18.	clan's Order dated 3/26/18 at vealed a phone order received Physician for, "x ray right femur, and right hip r/t pain." plogy Report dated 3/26/18 at "acute fracture involving the p There is a right subcapital t displacement" e's Note dated 3/26/18 at 2100 ad, "mobile xray resultes called sined to send resident to ER for Eval. and Tx. as ordered. Service to transport" view of the Medication sport for March 2018 revealed 23/18 for pain to be assessed and review revealed a pain cumented on the evening shift nued review revealed no pain management ther review revealed Resident vided with any pain interventions on the first complaint of pain rival at hospital (2305 or 11:05) evenue of a hospital Emergency evenued, "Initial Greet Date/Time 43PM)."			What measure will be put Into place or what systematic changes you will make to ensure that the deficient practice does not recur; and A QAPI team consisting of three (3) nurses has been assigned to review all incident investigation reports to ensure accuracy and completion; including updating the care plan. How the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurprogram will be put into place. The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant	wlik	
	i Further raview re	6/18 at 11:05 PM for pain. vealed 16 hours had passed 239 received treatment or pain				watton also	el Page 10 o

05/02/2018 WED 16:13 FAX 6157417051 TDON HCF

OF LICALTH AND HIMAN SERVICES

Ø1016/039 PRINTED: 05/02/2018 FORM APPROVED

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES		OME	NO. 0938-039	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
STATEMENT	OF DEFICIENCIES	IDENTIFICATION NUMBER:			ÇÇIVII CETED	
		445170	B. WING		04/18/2018	
	PROVIDER OR SUPPLIER	1440170		REET ADDRESS, CITY, STATE, ZIP CODE		
				O HICKORY HOLLOW TERRACE		
GOOD S.	AMARITAN HEALTH	AND REHAB CENTER	Al	NTIOCH, TN 37013		
(X4) ID PREPIX TAG	MACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETIC	
	: ****		, , ,	Administrator, DON,		
ERNO	Continued From pa	age 10	. F 600!	DSD, QA Coordinator, MDS		
F 000		fracture which occurred on	1	Coordinator, Activity Manager,	1	
	3/26/18 at 5:00 AM	L.	1	Dietary Manager, Rehab	\$	
	5		1 3	Manager, Social Services	÷	
	Interview with the D	Director of Nursing (DON) on	1	Director, Medical Records	i	
	4/18/18 at 8:30 AM	in her office revealed she was sident #239's fall on the	1	Manager and RN/CNT.	i	
	made aware or re-	The DON said she was	1	Monitoring will be		
	notified by the seco	and shift nurse of the X-ray	1	conducted daily, weekly,	4	
	results. The DON of	confirmed the facility tailed to	1	monthly or as ordered by	î	
	implement measur	es to prevent an accident fracture for Resident #239		the Medial Director.	34	
	(HARM).	Tracture for Resident #255		-	92 til	
F 641	Accuracy of Asses	sments	F 641		17	
SS=D	CFR(s): 483.20(g)			What corrective action(s)		
	*		10	will be accomplished for	9	
	· 5483.20(g) Accura	cy of Assessments. nust accurately reflect the		those residents found to	(\$7). (#)	
	i rooldant's status.		<u>.</u>	have been affected by the	(40	
5	This REQUIREME	NT is not met as evidenced	i	deficient practice.	006) Dec	
	by:	record review and interview				
	the facility failed to	accurately assess the use of		The Physician order, the	0) 0)	
	insulin on the Mini	mum Data Set (MDS) for 1 or		MAR and the diagnosis for	#1 #15	
	42 sampled reside	nts (Resident # 60) reviewed.		resident #50 was reviewed	ħ.	
	: : Findings include:			to ensure insulin was given.	8	
	1		Ţ.	1.4 1.45.	1	
	Medical record rev	iew revealed Resident #50 was	i	Staff reviewed the MDS -	2	
	admitted to the fac	ellity on 11/9/17 with diagnoses		Section N0350 for resident		
	Coizures and Type	Hypertension, Osteomyelitis, 2 Diabetes Mellitus.		#50 on 2/12/18. The error	i	
	iii			was corrected on 4/18/18	. !	
	Medical record rev	view of a Quarterly MDS dated	t t	by modifying the proper		
	2/12/18 for Reside	nt #50 revealed the resident		code to reflect insulin given	4	
	did not receive any period.	Insulin during the 7 day review		times seven (7) days.		
	ponou.		1	(SEE ATTACHMENT "F")		
1	S	11 1450 AMEMO 11:07	gt 8	į	t	

Interview with Resident #50 on 4/16/18 at 11:27

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

04/18/2013

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013

PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DAT CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 600 F 600 - Continued From page 10 interventions for a fracture which occurred on 3/26/18 at 5:00 AM.

Interview with the Director of Nursing (DON) on 4/18/18 at 8:30 AM in her office revealed she was made aware of Resident #239's fall on the morning it occurred. The DON said she was notified by the second shift nurse of the X-ray results. The DON confirmed the facility failed to implement measures to prevent an accident which resulted in a fracture for Resident #239 (HARM).

F 641 Accuracy of Assessments SS=D CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview the facility failed to accurately assess the use of Insulin on the Minimum Data Set (MDS) for 1 of 42 sampled residents (Resident # 50) reviewed.

Findings Include:

Medical record review revealed Resident #50 was admitted to the facility on 11/9/17 with diagnoses including Cellulitis, Hypertension, Osteomyelitis, Seizures and Type 2 Diabetes Mellitus.

Medical record review of a Quarterly MDS dated 2/12/18 for Resident #50 revealed the resident did not receive any insulin during the 7 day review period.

Interview with Resident #50 on 4/16/18 at 11:27

F 641

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

4/18/18 all residents with insulin orders were identified utilizing the "Order Listing Report" from PCC.

During the scheduled Care Plan Conference (Quarterly, Annual or Significant Change), MDS staff will again review all current medications to ensure they are appropriately coded in the MDS assessment.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES Ø16/03 PRINTED: 06/02/2 FORM APPROV OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
	9	445170	B. WING	a militar a same construction and a same	04/18/201		
	PROVIDER OR SUPPLIER AMARITAN HEALTH	AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013				
(X4) ID PREFIX TAG	RACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE		
F 641 SS≂D	Interview with the I 4/18/18 at 8:30 AM made aware of Remorning it occurrentified by the secresults. The DON complement measure which resulted in a (HARM). Accuracy of Asses CFR(s): 483.20(g) §483.20(g) Accurate The assessment measurement resident's status. This REQUIREME by: Based on medical the facility failed to insulin on the Minimulated to the facility failed to insulin on the facility failed to insulin on the Minimulated to the facility failed to insulin on the Minimulated to the facility failed to insuling Cellulitis, Seizures and Type Medical record rev 2/12/18 for Reside did not receive any period.	fracture which occurred on I. Director of Nursing (DON) on I in her office revealed she was sident #239's fall on the d. The DON said she was and shift nurse of the X-ray confirmed the facility falled to ses to prevent an accident fracture for Resident #239 sments by of Assessments. Cy of Assessments.	F 64		matic o t and eview or to ccuracy oS coding, iven to uracy of		
1	Interview with Resi	dent #50 on 4/16/18 at 11:27		3			

05/02/2016 WED 16:14 FAX 6157417051 TOOH HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE OMB NO. 0938-035

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		445170	B. WING		. 0	04/18/2018	
	PROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 600 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013	in the same		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETIO DATE	
F 655 SS=G	Injections daily. Medical record reviet dated 11/9/17 revea 6 units subcutaneous Diabetes. Continued dated 11/9/17 for La insulin 20 Units subrelated to Type 2 Diameted Resident # and Lantus insulins 2/28/18. Interview with Regis Coordinator) on 4/18 conference room co accurately assess R on the Quarterly MD Baseline Care Plan CFR(s): 483.21(a)(1) S483.21 Comprehen Planning \$483.21(a) Baseline \$483.21(a)(1) The fairnplement a baseline that includes the instended the instended to the profession The baseline care plan (i) Be developed with admission.	ew of Physician's Orders led an order for regular insulinusly 3 times a day for Type 2 direview revealed an order intus (long acting insulin) cutaneously at bedtime abetes. ew of the "Blood Sugar ord" for February 2018 60 was administered regular as ordered from 2/1/18 - tered Nurse #2 (MDS 8/18 at 9:40 AM in the infirmed the facility falled to esident #50's use of insulinus dated 2/12/18.)-(3) Isive Person-Centered Care Care Plans icility must develop and e care plan for each resident fructions needed to provide centered care of the resident al standards of quality care, an must- an Healthcare information		How the corrective action will be monitored to enthe deficient practice with deficient practice with assurance program will put into place. The QAPI Committee with monitor the effectiveners of the interventions implemented and the members include Administrator, Administrator, DON, DSD, QA Coordinated MDS Coordinator, Activity Manager, Dietary Manager, Dietary Manager, Medical Record Manager and RN/CNT. Monitoring will be conducted by the Medial Director of the Medial Director	tor, ty ger, services ds ucted r as		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ø018/039 PRINTED: 05/02/2011 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		445170	B. WING _		04/18/2018
	PROVIDER OR SUPPLIE AMARITAN HEALT	HAND REHAB CENTER		STREET ADDRESS, CITY, STATE ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013	
(X4) ID PREFIX TAG	(EACH DEFICIE)	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETION
TAG	Continued From Including, but not (A) Initial goals b (B) Physician ord (C) Dietary order (D) Therapy service (F) PASARR reconstruction (F) Is developed to admission. (II) Meets the requipment of the baseline of	page 12 Ilmited to- ased on admission orders. ers. s. lices. es. emmendation, if applicable. e facility may develop a are plan in place of the baseline emprehensive care plan- within 48 hours of the resident's uirements set forth in paragraph (excepting paragraph (b)(2)(i) of the facility must provide the representative with a summary are plan that includes but is not als of the resident. It the resident medications and	F65	What corrective action(s)	£239 clons .8/18 uded esident
	on behalf of the f (iv) Any updated of the compreher This REQUIREM by: Based on facility review and interv interventions on a sampled resident which resulted in the provider's non negative outcome	acility. information based on the details insive care plan, as necessary. ENT is not met as evidenced policy review, medical record iew, the facility falled to identify a baseline Care Plan for 1 of 27 is (Resident #239) reviewed a HARM (a situation in which incompliance resulted in a situation and/or reach his/her	TOTAL CONTINUES	not be limited to the following: Initial goals based on admission Orders, Physic orders, Dietary Orders, Therapy services, Social Services, PAŞARR recommendation, if applicable, Risk, Benefits or Interventions related to plan of care.	₩1 ₩1 ₩1 ₩2

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/02/201 FORM APPROVEI OMB NO. 0938-039 (X3) PATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COMPLETED	
		445170	B. WING_		<u>υ</u> ,	4/18/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HEALTH AND REHAB CENTER			SYREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013			
(X4) ID PREFIX TAG	/FACH DEFICIÊN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	ULD BE	GOMPLETION GATE
TOOL COME. TO DESCRIPTION OF THE PARTY OF TH	psychosocial well accurate and com assessment, plan services) for the interventions to k identification as 'f Findings include: Review of facility dated 11/28/17 reresident's Immed maintained, a bas developed within resident's admissible used until the comprehensive a interdisciplinary p Medical record rewas admitted to t readmitted on 4/2 Fracture of Unspremur, Hallucina Muscle Weaknes and Mobility, Head Diverticulosis of Scardiomyopathy, Disease, Adult Fangle-Closure Gl Medical record redata Set dated 3/2 had a Brief Interving Indicating mile extensive assista dressing, tolieting	physical, mental and labeling as defined by an imprehensive resident in of care and provision of facility's failure to provide fall eep the Resident safe after nigh' falls risk. policy "Baseline Care Plana" evealed "To assure that the liste care needs are met and seline care plan will be torty-eight (48) hours of the staff can conduct the saessment and develop an erson-centered care plan" Aview revealed Resident #239 he facility on 3/23/18 and 2/18 with diagnoses including ecified Part of Neck of Right tions, Other Reduced Mobility, is, Other Abnormalities of Galt art Fallure, Altered Mental Status, Small Intestine, Ischemic Chronic Obstructive Pulmonary allure to Thrive and Acute	F 6	What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and A QAPI team consisting of three (3) nurses has been assigned to review all care plans within forty-eight (48) hours of admission to ensuraccuracy and completions. (SEE ATTACHMENT "G"	e ''')	al Page 14 of

05/02/2018 WED 16:15 FAX 6157417051 TOOH HCF

EPARTMENT OF	HEALTH AND	HUMAN	SERVIC	CES

Ø1020/039
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FORM APPROVE
OMB NO. 0938-039
WAN BATE OUDLEY

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				TE SURVEY
TIATOMENT OF CONTROL TO THE PROPERTY OF THE PR		1	LE CONSTRUCTION		MPLETED	
		445170	9, WING			/18/2018
	PROVIDER OR SUPPLIER	AND REHAB CENTER	5	STREET ADDRESS, CITY, STATE, ZIP COD 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013		1116:19 H
(X4) ID PREFIX TAG	WACH DEPICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETIO DATE
F 655	only able to stabilize moving from a sea Further review reversik for falls and has admission. Medical record revevidence based to simple assessment falling) dated 3/23/revealed Resident (Scoring: Low Risk High Risk 45 or high Continued review of factors were docurd. Yes, the Resider on the chart. (Secondary 1. Yes, the Resider apparatus or hepathology for the ground. Sc. grasps furnambulating. Cannot for Yes, the Resider fimits. RESULTS: High R. SCORE: 90	e resident was not steady and be with staff assistance for ted to standing position. The ealed Resident #239 was at ad a fall with major injury since liew of a "Morse Fall Scale" (and to fa patient's likelihood of 18 at 2349 (11:49 PM) #239 had a score of 90 to -24, Moderate Risk 25-44, ther) Indicating High Risk. The ealed the following risk mented: In that fallen before. (History) at has more than one diagnosis and any Diagnosis) at uses crutches, cane or y Ald) to does not have an intravenous rin lock inserted. (IV or IV ealred: In the ease of the early watches and the ease of the early watches and the ease of the early watches to rise. It was the ease of the early watches the walk unassisted. It walk unassisted. In the ease of forgets walk unassisted.		How the corrective action be monitored to ensure the deficient practice will not recur; i.e., what quality as program will be put into possible the interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director.	e surancė lace.	

05/02/2018 WED 16:16 FAX 5157c17051 TDOH HCF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 05/02/2011 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	(X0) DATE SURVEY COMPLETED	
		445170	B. WING		04/18/2018
	PROVIDER OR SUPPLIER AMARITAN HEALTH	AND REHAB CENTER	500	EET ADDRESS CITY, STATE, ZIP CODE HICKORY HOLLOW YERRACE TIOCH, TN 37013	
(X4) ID PREFIX TAG	LEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 689	Further review revidocumented throuse documented throuse regarding falls. Medical record revihad a fall on 3/26/fracture (HARM). It resident was admit and received surgeright hip fracture. Interview with the 4/18/18 at 8:30 AN Resident #239 had risk. The DON considentify fall interver Plan for Resident #239 had risk. The DON considentify fall interver Plan for Resident #CFR(s): 483.25(d) Accident Free of Accident HCFR(s): 483.25(d) The as free of accident \$483.25(d)(1) The as free of accidents. This REQUIREMED by: Based on medica Orders, Radiology investigation and It prevent an accident	ed falls as a safety concern. caled no identified Interventions about Resident record liew revealed Resident #239 Is which resulted in a femure further review revealed the ted to the hospital on 3/26/18 ary on 3/28/18 to repair the Director of Nursing (DON) on the her office revealed to the hospital as a high fall firmed the facility falled to ations on the Baseline Care #239. azards/Supervision/Devices (1)(2) Ints. Insure that - resident environment remains thazards as is possible; and a resident receives adequate asistance devices to prevent in the proof of the prevent in th	F 689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility assigned a "Sitter" to be in the room with resider #239 4/17/18 @ 7:01pm. and will continue to be in the room until resident is stable.	
Omid Chie d	587(02-99) Previous Version	s Obsolete Event ID: 24XE1:	1 Facili	lly ID: TN1909 If continu	ation sheet Page 16 of 2

05/02/2018 WED 16:16 FAX 6157417051 TOOH HOF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES Ø1021/039 PHIN : ED: 05/02/201 FORMAPPROVEI OMB NO, 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIAND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		COMPLETED	
		445170	B. WING			1/18/2018
	PROVIDER OR SUPPLIE AMARITAN HEALTH	R AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013		
(X4) ID PREFIX TAG	JEACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	COMPLETION DATE
F 689	Further review revidocumented throuse regarding falls. Medical record rehad a fall on 3/26 fracture (HARM). resident was admand received surgight hip fracture. Interview with the 4/19/18 at 8:30 Al Resident #239 har risk. The DON condentify fall interve Plan for Resident Free of Accident Free	led falls as a safety concern. I vealed no Identified interventions alghout Resident record. I view revealed Resident #239 I 8 which resulted in a femur. Further review revealed the alted to the hospital on 3/26/18 pery on 3/28/18 to repair the. Director of Nursing (DON) on Min her office revealed to antions on the Baseline Care #239. Hazards/Supervision/Devices I 1 (2) I 1 (2) I 2 ents. I 2 resident environment remains at hazards as is possible; and the resident receives adequate resistance devices to prevent. ENT is not met as evidenced al record review, Physician's y Report, Nurse's Notes, facility Interview, the facility failed to ent which resulted in a fracture and residents (Resident #239)	F 68		e plan 4/17/18. s te	
	f		1	Contract of the Contract of th		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ø1022/039 PRINTED: 05/02/2016 FORM APPROVEL OMB NO. 0938-0391

		8 MEDICAID SERVICES		TIOLE	CONSTRUCTION	(X3) DA	TE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		446170	B. WING				/18/2018
	PROVIDER OR SUPPLIER	AND REHAB CENTER		500	REET ADDRESS, CITY, STATE, ZIP CODE 3 HICKORY HOLLOW TERRACE ITIOCH, TN 37013		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BIE	COMPLETION DATE
F 689	Investigation" date on previous evaluated will Identify in resident's specific prevent the reside minimize complice with the Input of the identify appropriated of falls" Medical record reviwas admitted to the readmitted on 4/2/2 Fracture of Unspecture of Unspectur	colicy "Fall Prevention and d 11/28/16 revealed " Based etions and current data, the terventions related to the risks and causes to try to interest from failing and to try to stions from failing. The staff, e Attending Physician, will interventions to reduce the recommendation of the revealed Resident #239 in facility on 3/23/18 and 18 with diagnoses including cified Part of Neck of Right fuced Mobility, Muscle Abnormalities of Galt and fure, Altered Mental Status, mall Intestine, Ischemic Chronic Obstructive Pulmonary flure to Thrive and Acute sucome. View of a Discharge Minimum 26/18 revealed Resident #239 ew for Mental Status score of ferate cognitive impairment; a pasistance with bed mobility, it tolleting and personal hygiene dependence for bathing, revealed the resident was not be to stabilize with staff er review revealed Resident for falls and had a fall with major		689	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; An audit was conducted of fall incidents for the period February, March and April Twenty-six residents were identified as high-risk for fall for the Morse Code Fall Assess was completed on all residents for the nursing staff regard "Safety Awareness", and Monitoring" beginning 4/ and will be on going to enall staff that were not preat the first training session receive the training prior beginning their shift. Stafwill document the monitoring rounds on the "Monitoring Form/Sheet (In-Services Training Sheet (In-Services T	the dof 2018. alls. sment dents. ren ding "Fall 17/18 asure esent on to ff et s.". ets **MC-N** " H will is	9 3

05/02/2018 WED 16:16 FAX 6157417051 TOOK HCF

DEPARTMENT OF HEALTH AND HUMAN SERVICES

7022/039 PRINTED: 05/02/2018 FORMAPPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	445170	B. WING		04/18/2018
(A) IV	AND REHAB CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	500	REET ADDRESS, CITY, STATE, ZIP CODE HICKORY HOLLOW TERRACE TIOCH, TN 37013 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE	OFD RELLAND
Investigation" date on previous evaluated staff will identify in resident's specific prevent the reside minimize complice with the input of the identify appropriate risk of falls" Medical record reviwas admitted to the readmitted on 4/2/Fracture of Unspective of Unspective of Unspective of Unspective of Unspecticulosis of Stardiomyopathy, Disease, Adult Fall Angle-Closure Glama Set dated 3/2 had a Brief Intervious Set dated 3/2 had a Brief Intervi	olicy "Fall Prevention and d 11/28/16 revealed "Based ations and current data, the terventions related to the risks and causes to try to not from falling and to try to tions from falling. The staff, e Attending Physician, will a Interventions to reduce the lew revealed Resident #239 a facility on 3/23/18 and 18 with diagnoses including cified Part of Neck of Right uced Mobility, Muscle Abnormalities of Gait and lure, Altered Mental Status, mall Intestine, Ischemic Chronic Obstructive Pulmonary flure to Thrive and Acute nucoma. View of a Discharge Minimum 26/18 revealed Resident #239 as for Mental Status score of lerate cognitive impairment; a assistance with bed mobility, g, toileting and personal hygiene dependence for bathing. revealed the resident was not bie to stabilize with staff er review revealed Resident for falls and had a fall with major		What measure will be put into place or what systematichanges you will make to ensure that the deficient practice does not recur; and in addition to Nurses and CN conducting daily routine monitoring on the residents identified as "high-risk" fall falls, supervisory monitoring will be made by Managemer Staff Q2hrs to ensure the Environment remains as free of accident hazards as is pos Management staff monitorin assignments are as follows. Hallway – 100 – Medical Rec Mgr. Hallway – 200- MDS Coordin Hallway – 300- Dietary Mgr. Hallway – 300- Rehab & Diet Hallway – 500- Rehab & Diet Hallway – 500- QA Coordina	Ts it sible, ng ords ator lgr. ary Mgr.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

MI023/039 PRINTED: 05/02/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORREC'TION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
	445170	B. WING		04	/18/2018	
PREFIX (EACH DEFICIENCY	AND REHAB CENTER TEMBRIT OF DEFICIENCIES F MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	500	PREST ADDRESS, CITY, STATE, ZIP CODE HICKORY HOLLOW TERRACE ITIOCH, TN 37013 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X8) COMPLETION DATE	
was found in a room on the floor behind revealed at 6:30 AM pain to the right this revealed Resident fracture at 5:00 AM Director/Altending FAM and 8:30AM with Review of a Physici 1449 (2:49PM) revealed, 2:49PM) revealed, and a subcapital hip. If acture with slight of Review of a Nurse's (9:00 PM) revealed, and a made aware of Resident fracture with the Director with the Director of Resident fracture with	at 5:00 AM Resident #239 in across from her room, sitting a couch. Continued review of the resident complained of the resident resulting in and the Medical Physician was notified at 7:30 in response documented. an's Order dated 3/26/18 at taled a phone order received ysician for, "x ray right femur, and right hip r/t pain." There is a right subcapital lisplacement" Note dated 3/26/18 at 2100 "mobile xray resultes called ad to send resident to the reside	F 689	How the corrective action(s will be monitored to ensure the deficient practice will necur; i.e., what quality assurance program will be put into place. The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Plant & Maintenance Manager, Medical Records Manager and RN/CNT. Monitoring will be conducted dally, weekly, monthly or as ordered by the Medial Director.	ot		

05/02/2018 WED 16:17 FAX 6157417051 TDON HOP DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445170		A. BUILDING			COMPLETED	
		B WING_		04/18/2018		
	PROVIDER OR SUPPLIER AMARITAN HEALTH A	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013	¥	5
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\$S=G	provided to resident consistent with profithe comprehensive and the residents gard the residents. This REQUIREMENT by: Based on medical the facility failed to post-fall with a fract complaints of pain f (Resident #239) rev. Findings Include: Medical record reviews admitted to the readmitted on 4/2/11 Fracture of Unspecifemur, Other Reduived Weakness, Other A Mobility, Heart Fallu Diverticulosis of Sm Cardiomyopathy, Ch Disease, Adult Failu Angle-Closure Glaud Medical record review Data Set dated 3/26 had a Brief Interview 11, indicating moder Continued review recomplaints of pain dispersions.	inagement. sure that pain management is is who require such services, essional standards of practice, person-centered care plan, oals and preferences. IT is not met as evidenced record review and interview, provide pain management ure (HARM) after verbal or 1 of 27 sampled residents iewed. ew revealed Resident #239 facility on 3/23/18 and 8 with diagnoses including fied Part of Neck of Right ced Mobility, Muscle bnormalities of Galt and re, Altered Mental Status, all Intestine, Ischemic incolic Obstructive Pulmonary re to Thrive and Acute	F 69		r	
		injury since admission.				<u> </u>

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES Ø025/039 PRINTED: C5/02/2018 FORM APPROVED OMB:NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	A, BUILDING	PLE CONSTRUCTION 6	COMPLETED	
		445170	B. WING_	H. Sarris -	04/18/2018	
NAME OF PROVIDE	TAN HEALTH	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013 PROVIDER'S PLAN OF CORRECT	(ex) (O)	
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dated was for room review comp Physic Medic 3/26/* "Brown to state second for the second for	cal record revenued sitting of across the hard revealed all lained of pallical Therapists at record revealed and record revenued in parallel and record record record in parallel and record and recor	view of facility investigation called at 5:00 AM Resident #239 on the floor behind a couch in a all from her room. Continued 6:30 AM the resident to the right thigh to the 1 (PT). View of a statement dated Physical Therapist #1 revealed to P.T. [physical therapy] gymbars. Patient unable to Patient then told therapist she ist took patient back to nurse patient's pain" View of a statement dated Licensed Practical Nurse #6 proximately 7AM patient was in complained of pain to right legals apported to this writer by the ad the c/o [complaint of] pain to right legals and reported to this writer by the ad the c/o [complaint of] pain to right legals and residual paints of the course	F 69	In-service training was given to the nursing staff beginning 04/17/18 regarding "Pain Management"; Including recognizing when the residen is experiencing pain and identifying circumstances when pain can be anticipated. (In-service Training Sheets attached). — A In-services will be on going to ensure all staff that were not present at the first training session receive the training prior to beginning their shift. What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and The Management Staff conducting daily Supervisory monitoring will utilize the "IDT Daily Rounds Report Sheet" to document the findings. Questions #5 & #6 on the form relates to Pai (See Attachment "B").	t G"	

05/02/2018 WED 16:19 FAX 6157417051 TOOH HOF DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		COMPLETED	
	445170	B. WING.		04	/18/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013			
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fracture with slight Review of a Nurse (9:00 PM) revealed to MD. Order obta [hospital named] E AMR ambulance s Medical record rev Administration Rej an order dated 3/2 every shift. Continut level of "4" doc of 3/26/18. Continut documentation of interventions. Furt #239 was not prov or medications from (6:30 AM) until arri PM). Medical record rev Provider Report rev 3/26/18 2243 [10:4] Medical record rev 3/27/18 revealed F administered Morp milligrams on 3/26 Interview with the I 4/18/18 at 8:30 AM made aware of Re occurred. The DOI the resident's com confirmed the facil management after	characteristics a right subcapital displacement" I's Note dated 3/26/18 at 2100 dr. "mobile xray resultes called inned to send resident to ER for Eval. and Tx. as ordered. Bervice to transport" I'ew of the Medication port for March 2018 revealed 3/18 for pain to be assessed used review revealed a pain cumented on the evening shift used review revealed no pain management her review revealed Resident ided with any pain interventions in the first complaint of pain that thospital (2305 or 11:05) I'ew of a hospital Emergency vealed, "Initial Greet Date/Time ISPM]."		Management staff monitoring assignments are as follows. Hallway-100- Medical Record Mgr. Hallway-200-MDS Coordinat Hallway-300-Dietary Mgr. Hallway-400-Comm. Relation Hallway-500-Rehab & Dietar Hallway-600-QA Coordinator Will be monitored to ensure the deficient practice will monitor the effectiveness of the interventions implemented and the include Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Plant & Maintenance Manager, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director.	ds or us Mgr. y Mgr. r si) e		

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PRINTED:	05/02/2018
FORM	APPROVED
OMB NO.	0938-0391

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DEPARTMENT OF THE	WEDLOND SERVICES
CENTERS FOR MEDICARE &	WEDICAID SERVICES
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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION A. BUILDING ____

(X3) DATE SURVEY COMPLETED

445170

04/18/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE

1	GOOD SAMARITAN HEALTH AND REHAB CENTER		1	ANTIOCH, TN 37013		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	11.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY)	COMPLETION DATE
	F 697: Continued From page 21	•	F 69	7		1

F 758

Refer to F-580, F-655, and F-689 Free from Unnec Psychotropic Meds/PRN Use F 758 CFR(s): 483.45(c)(3)(e)(1)-(5) SS≃D

> §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

- (i) Anti-psychotic;
- (ii) Anti-depressant;
- (iii) Anti-anxiety; and
- (Iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented In the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice

4/17/18 the Medical Director reviewed the medications of resident #239 and discontinued the psychotropic medication.

4/18/18 The Psyche NP evaluated and reviewed the medications of resident #239 and recommended not to resume PRN order. The record has been updated to meet the 14-day limitation rule.

4/18/18 The PRN psychotropic medication for resident #238 was reviewed by the PCP. A new order was received documenting the daily dose, frequency of administration and duration of use for the psychotropic medication.

M028/039

05/02/2	018 WED 16:20 1	FAX 6157417051 TOOK HOP AND HUMAN SERVICES			¥.	FORM	APPROVED . 0938-0391
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDI		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	(X3) DATE SURVEY COMPLETED	
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GOODSA		AND REHAB CENTER	ID PREF	500 AN	EET ADDRESS, CITY, STATE, ZIP GODE HICKORY HOLLOW TERRACE TIOCH, TN 37013 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
F 758	Continued From pare limited to 14 de §483.45(e)(5), if the prescribing practiti appropriate for the beyond 14 days, he rationale in the residents (Findings are limited to renewed unless the prescribing practite the appropriatene. This REQUIREM by: Based on medicate the facility failed to psychotropic medicate for continuationale for continuati	age 22 ays. Except as provided in the attending physician or oner believes that it is a PRN order to be extended to restend their sident's medical record and on for the PRN order. Norders for anti-psychotic to 14 days and cannot be the attending physician or interested the resident for so of that medication. ENT is not met as evidenced all record review and interview, to ensure as needed (PRN) dications had a 14 day limitation to the medical and the resident for 2 of 7 sampled and #238 and Resident #238 and Resident #238 the facility on 3/26/18 with the facility of 3/26/18 with the faci	F	× 758	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The Psyche NP re-evaluated all residents receiving PRN psychotropic medications to determine if the order show be extended beyond 14-day. Those identified as needing the PRN order extended beyond 14-days, the prescribing Practitioner documented the rationale. The resident's chart was updated to reflect same.	o Id	
	Michaelanca (II)	ronic Obstructive Pulmonary cular Degeneration.	ļ				

date.

Medical record review of a Physician's Order dated 3/26/18 revealed Clonazepam (antianxlety) 1 mg (milligram) every 12 hours as needed for agitation. Continued review revealed no stop

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PRINIED: 05/02/2018 FORM APPROVED OMB NO, 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(X3) DATE SURVEY

CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 04/18/2018 446170 STREET ADDRESS, CITY, STATE, ZIP CODE 500 HICKORY HOLLOW TERRACE NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HEALTH AND REHAB CENTER ANTIOCH, TN 37013 COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE tD SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 758 F 758 Continued From page 22 are limited to 14 days. Except as provided in §483.45(e)(5), If the attending physician or prescribing practitioner believes that it is What measure will be put appropriate for the PRN order to be extended beyond 14 days, he or she should document their into place or what systematic rationale in the resident's medical record and changes you will make to Indicate the duration for the PRN order. ensure that the deficlent practice does not recur; and §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or All newly admitted residents prescribing practitioner evaluates the resident for With psychotropic medications the appropriateness of that medication. Will be assessed by the This REQUIREMENT is not met as evidenced Community Relation Staff, Based on medical record review and interview, Admitting Nurse and IDT the facility failed to ensure as needed (PRN) members during the initial psychotropic medications had a 14 day limitation Care Plan Conference. or prescriber documentation with medical rationale for continuation for 2 of 7 sampled Referrals will be made to the residents (Resident #236 and Resident #239) appropriate Practitioner, e.g. reviewed. PCP, Psyche NP and/or Pharmacy Consultant to ensure Findings include: The 14-ay evaluation is being Medical record review revealed Resident #238 was admitted to the facility on 3/26/18 with enforced according to regulation. diagnoses including Right Foot Pathological Fracture, Anxiety Disorder, Major Depressive During the weekly Drug Regime Disorder, Dementia without Behavloral Committee Meeting, 14-day rule Disturbance, Chronic Obstructive Pulmonary for PRN medications will be Disease and Macular Degeneration. discussed to ensure compliance. Medical record review of a Physician's Order dated 3/26/18 revealed Clonazepam (antianxiety) (SEG ATTACHMENT """) 1 mg (milligram) every 12 hours as needed for

date.

agitation. Continued review revealed no stop

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03/04/2020	FAX 6157417051 TOOH HCF	y	8	PRINTED: 0 FORM AI OMB NO. 0	PPROVED
DEPARTMENT OF HEALTH CENTERS FOR MEDICARE TATEMENT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE :	SURVEY
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	AND REHAB CENTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	500	HICKORY HOLLOW TERRACE TIOCH, TN 37013 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION	(X5) COMPLETION DATE
F 758 Continued From particles of Medical record revision Administrated the reside medication on the 3/28/18, 3/30/18, 4/4/18, 4/5/18 (twice 4/12/18 through 4/2/18 through 4/2/18 through 4/2/18 revealed the readmitted on 4/2/2/18 revealed 4/2/18 revealed 4/2/18 revealed 4/2/18 revealed the reside medication on the 4/7/18 through 4/3/2/18 through 4/3/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	age 23 liew of March 2018 - April 2018 stration Record (MAR) ent was administered the following dates: 3/27/18, 4/1/18, 4/2/18, 4/3/18 (twice), 20, 4/6/18 through 4/9/18, 15/18 and 4/17/18. liew revealed Resident #239 e facility on 3/23/18 and 18 with diagnoses including cified Part of Neck of Right ons and Altered Mental Status. liew of a Physician's Order aled Zyprexa (antipsychotic) 2.5 is as needed for agitation, revealed no stop date. liew of the April 2018 MAR lient was administered the following dates: 4/3/18, 4/5/18,		How the corrective action be monitored to ensure deficient practice will not recur; i.e., what quality program will be put into the QAPI Committee will monitor the effectivenes of the interventions implemented and the members include Admir Assistant Administrator, DON, DSD, QA Coordinator, Activ Manager, Dietary Manager, Dietary Manager, Dietary Manager, Dietary Manager, Social Services Director, Media Records Manager and RN/CNT. Monitoring we conducted daily, week monthly or as ordered the Medial Director.	the ot assurance place. Il ss histrator, otor, otty ager, lical iii be	

PRINTED: 05/02/201 05/02/2018 WEG 16:21 FAX 6157417051 TOOM HCF FORM APPROVE DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE BURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND FLAN OF CORRECTION A. BUILDING _ 04/18/2018 445170 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 500 HICKORY HOLLOW TERRACE GOOD SAMARITAN HEALTH AND REHAB CENTER ANTIOCH, TN 37013 (X8) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) TAG What corrective action(s) F 800 F 800 | Continued From page 24 will be accomplished for preferences of each resident. those residents found to This REQUIREMENT is not met as evidenced have been affected by the Based on facility policy review, observation and deficient practice Interview the facility falled to serve milk and protein shakes at the appropriate temperature for All milk and shakes sitting consumption for 87 residents. at tray line was discarded and replaced with cold milk Findings Include: and shakes retrieved from Review of facility policy "Food Temperature and the refrigerator at Preparation Service" revised 11/28/17 revealed appropriate temperature. "...The danger zone for food temperature is between 41 F [Fahrenhelt] and 135 F [Fahrenheit]. This temperature range promotes the rapid growth of pathogenic microorganisms How will you identify other that cause foodborne Illness. Potentially residents having the hazardous foods include meats, poultry, seafood, potential to be affected by cut melon, eggs, milk, yogurt, and cottage the same deficient practice cheese..." and what corrective action Observation on 4/16/18 at 12:36 PM In the dietary will be taken; department revealed milk and protein shakes (which contained milk products) were individually wrapped in plastic glasses placed on metal trays Milk and Shakes will remain on racks during plating of the food. Continued In the freezer until thirty (30) observation revealed the milk temperature was minutes prior to service. Milk 42 degrees Fahrenhelt and the protein shakes and shakes will be placed on were 44 degrees Fahrenheit. These temperatures were not within the safe range for consumption or ice immediately after retrieval from freezer. Temperature distribution. will be checked before, during, Interview with the Food Service Supervisor on and after tray line service. 4/16/18 at 12:40 PM in the dietary department confirmed that the milk and protein shake were Temps will be maintained not within the appropriate and safe range for Below 40 degrees. (SEE ATTACHMENT "K" consumption. Interview Food Service Supervisor on 4/18/18 at

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1	Intendew Food S	ervice Supervisor on 4/18/18 at	: }		continuation sh	nel Pece 2
1	THE MAN LOOK O	41 11 4 = -11		Spolith ID: TN1909	continuation au	COLL NAC W.

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DEPARTMENT OF HEALTH AND HUMAN	SERVICES
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F 800	a are and in his off	ica confirmed the facility lailed	1	The members include	
	the same and the come	Apple States of the	1	Administrator, Assistant	#.1
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